



Department of Health
and Human Services

Maine People Living
Safe, Healthy and Productive Lives

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November 7, 2012

Richard R. McGreal, Associate Regional Administrator
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JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Dear Mr. McGreal:

Please find enclosed a final report analyzing Maine's Private Non-Medical Institutions (PNMI) to determine whether these settings are Institutions for Mental Disease (IMD). This analysis and report have been conducted in response to your letter of August 9, 2011.

The Department engaged in a thorough and methodical analysis of Private Non-Medical Institutions (PNMI), including Substance Abuse facilities, Children's facilities, Community Residences for Members with Mental Illness, Case Mix facilities, and Non-Case Mix facilities. A description of each of these PNMI programs, resident characteristics, and services rendered in each setting are contained in this report.

Maine's PNMI programs deliver high quality community integrated services in the least restrictive settings for individuals with various service needs who otherwise might require institutional level of care in nursing facilities, ICF-MR, or hospitals. Most of these PNMI programs are in residential facilities with homelike settings with no more than 16 beds. Generally, only those PNMI programs providing personal care services for older adults with chronic health conditions or physical disabilities have more than 16 beds. This model of residential care is provided only for those who would otherwise be unable to live in the community, and exemplifies Maine's successful progress toward de-institutionalization.

After careful and thorough analysis, Maine concludes that none of these PNMI settings meet the definition of IMDs. The attached report summarizes this determination.

We wish to express our gratitude for the technical assistance your staff provided and your flexibility in granting extensions to carefully complete this important analysis. Please do not hesitate to contact us should you wish to further discuss this report.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

cc: Bonnie Smith, Deputy Commissioner, Stefanie Nadeau, MaineCare Director

**State of Maine
Department of Health and Human Services**

**Maine DHHS Analysis of whether any MaineCare-funded Private Non-Medical Institution (PNMI)
Services Fit the Federal Medicaid Definition of IMD
November 7, 2012**

I. Introduction

The State of Maine Department of Health and Human Services administers Maine's Medicaid program, known as MaineCare. MaineCare reimburses services in various residential treatment programs licensed and reimbursed as "Private Non-Medical Institutions" (PNMI). These residential services provide services in least restrictive community settings for individuals who otherwise might require frequent or long term institutional services, such as services in a nursing facility, ICF-MR, or hospital. These residential programs are varied in their treatment design, and serve individuals with specialized treatment needs such as physical disabilities, chronic health conditions associated with aging, dementia, intellectual disabilities, behavioral health (including substance abuse), and traumatic brain injury. These residential programs vary in size (number of beds) with all PNMI, except those specializing in treatment of frail elders, having fewer than 16 beds in one physical location or building. Coverage and reimbursement of these PNMI programs is detailed in the MaineCare Benefits Manual, Chapters II and III, Section 97, Private Non-Medical Institution Services, and Appendix B, Substance Abuse Services; Appendix C, Case Mix Facilities; Appendix D, Child Care Facilities; Appendix E, Community Residences for Members with Mental Illness; and Appendix F, Non-Case Mixed Facilities. Provider agencies may operate one or more programs at various locations, often referred to in this report as "scattered site settings" when the setting has 16 or fewer beds, or "facilities" when the setting has more than 16 beds. These PNMI programs have evolved over many years to meet the service needs of a rural state. These PNMI typically have fewer than 16 beds in one setting, and in many cases have combined administrative functions (at DHHS request) to assure program efficiencies.

Background

On August 9, 2011, the State of Maine Department of Health and Human Services received a letter from Richard McGreal, Associate Regional Administrator, U.S. DHHS Centers for Medicare and Medicaid Services, expressing concern that some Maine Private Non-Medical Institutions (PNMI) might meet the definition of an Institution for Mental Disease (IMD), which in most circumstances, cannot receive federal funding. The letter asked that Maine DHHS "identify all PNMI facilities that meet the federal definition of an IMD and then immediately cease Medicaid claiming for services in that IMD." Mr. McGreal requested that this information be submitted within 60 days of the receipt of the letter.

Upon receipt of the August 9, 2011 CMS letter, Maine DHHS began the requested analysis of these facilities. Also, Commissioner Mary C. Mayhew began communicating CMS IMD concerns shortly after receipt of the August 9, 2011 letter to provider agencies, the Maine State Legislature, and the advocate community. She sent a copy of the August 9, 2011 CMS letter to all PNMI provider agencies on September 1, 2011, and at the same time identified additional concerns raised by CMS around PNMI reimbursement. She informed provider agencies that DHHS would immediately begin IMD assessment of PNMI beginning with telephone surveys. Provider agency surveys were conducted in September and October of 2011. DHHS quickly found this analysis complex partially due to the unique nature of Maine's PNMI programs. Both CMS and Maine DHHS consulted on the composition of several substance abuse PNMI programs that were initially identified as IMDs, and subsequently Maine DHHS rescinded that letter and requested more time for analysis. On November 8, 2011, Commissioner Mary Mayhew requested a six-month extension to assess PNMI scattered site locationsⁱⁱ. This extension was granted. An additional extension was then requested to assess the patient population in some of the larger facilities to determine whether more than fifty percent (50%) of the residents have a behavioral health diagnosis and treatment plan that resulted in the need for this residential level of care. CMS approved this additional extension in an April 13, 2012 letter.ⁱⁱⁱ Subsequently Maine DHHS requested and was granted an additional extension until November 7, 2012 to assess the patient population, referenced in this report as "Resident Level Analysis". This report summarizes Maine's findings of its IMD analysis.

Summary of Findings:

Maine completed a comprehensive review of its Private Non-Medical Institution (PNMI) services using guidance from federal guidelines to establish a standardized methodology for its review. Maine DHHS has concluded that none of its PNMI programs fit the definition of an Institution for Mental Disease (IMD). This report describes these residential programs, summarizes the methodology used to analyze them, and discusses the findings.

II. Overview of Methodology

Maine DHHS staff used a wide variety of approaches to analyze whether or not its PNMI programs may be IMDs. This section details the methodology.

Request for CMS Technical Assistance

Upon request of the August 9, 2011 letter, Maine DHHS requested additional CMS guidance and clarification around the IMD definition, which does not clearly apply to these scattered site residential PNMI programs. Maine DHHS and CMS staff communicated through several conference calls and emails, and the Maine DHHS was directed to review and utilize the IMD definition in Section 4390 of the ***CMS State Medicaid Operations Manual*** in making its IMD

determination. Maine DHHS staff were asked to apply the following criteria to PNMI programs in determining whether or not these programs are an IMD: 1) Is the facility licensed as a psychiatric facility; 2) Is the facility accredited as a psychiatric facility; 3) Is the facility under the jurisdiction of the State's mental health authority; 4) Does the facility specialize in providing psychiatric/psychological care and treatment; and 5) Does the current need for institutionalization for more than 50% of all the patients in the facility result from mental disease?

Maine DHHS staff found that these questions do not clearly apply to Maine's PNMI programs, requiring further analysis.

Guidance from CMS State Medicaid Operations Manual

The language in the CMS State Medicaid Operations Manual, Section 4390, was last updated in 1997, and references separate "components" certified as different types of providers, which vaguely appear to apply to the "scattered site" settings Maine utilizes in many of its PNMI programs to assure that services are delivered in least restrictive community-based homelike settings. Maine DHHS staff began analysis of these separate "components" or "scattered sites" and subsequently determined that additional time would be necessary to complete the IMD analysis. Telephone surveys were conducted with provider agencies, and all data were validated by DHHS staff to assure understanding of these PNMI programs.

Maine DHHS staff set about developing a plan to gather information from Section 4390, which emphasizes applying criteria to the appropriate entity. DHHS staff found it necessary to gather information for each PNMI program including: ownership, governing body, shared medical officers, chief executive officer, separate licensure, organizational and geographic separation, and independence in functioning.

Section 4390 states:

4390. INSTITUTIONS FOR MENTAL DISEASES

A. *Statutory and Regulatory Provisions.*--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. *IMD Coverage.*--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the

component has 16 or fewer beds.

- C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;
2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and
5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

- D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

Consultation with Other States

Maine DHHS staff consulted with several other states around their IMD analysis methodology, and conducted several conference calls with state staff in North Carolina. North Carolina staff shared their methodology and assessment tools used in their IMD analysis. Maine DHHS staff

used all relevant information provided by North Carolina to establish a research protocol that included communications with all of its PNMI agency providers.

Development of Telephone Survey Assessment Tool

DHHS staff developed and utilized a telephone survey tool^{iv} designed to gather information referenced in Section 4390 of the Medicaid Manual. The survey data collected numerous details about treatment and administrative functions of these PNMI programs regarding the five primary questions from above, as well as additional information on separate components of the PNMI programs. Maine DHHS program staff administering these programs were also asked to complete program descriptions and to validate the information received from PNMI provider agencies. Data was also validated with MaineCare enrollment and Licensing information. Maine staff conducted a very thorough and extensive data collection and analysis to report back the requested information to CMS. *Though the information received from provider agencies is very useful in better understanding the wide variety of these programs, it most importantly confirmed that Maine's unique PNMI programs do not meet the IMD definition provided in Section 4390.*

Scattered Site Analysis

Maine DHHS reimburses residential "PNMI" services in community based scattered site settings that do not fit the definition of a "facility", or "institution. Maine DHHS staff determined that further analysis of separate components was necessary due to this unique model, and requested an extension. Maine DHHS Staff analyzed scattered site data obtained from provider agencies and DHHS program staff, closely following Section 4390 and a DHHS diagram^v intended to assist staff through a decision tree assessment of the IMD criteria. Maine DHHS affirms that these facilities are not IMDs, but has adopted a scattered site definition for its residential programs with the intent that it will prevent future concerns regarding scattered site settings (separate components) being IMDs.

Assessment of Patient Population (Resident Level Analysis)

Maine DHHS encountered an additional challenge of the CMS requested IMD analysis in analyzing those larger facilities reimbursed under Appendix C, called "Case Mix" facilities. These facilities specialize in providing personal care services to aging adults with chronic health conditions and physical disabilities resulting in the inability to live in their own home, often alone. The population served in these facilities frequently experiences depression, dementia, or other behavioral health challenges along with extensive chronic health conditions and physical disabilities. The challenge in this analysis was to identify the primary reason for each individual requiring this level of care. Upon request for additional guidance, Maine DHHS again was directed to Section 4390 of the Medicaid Manual. Section 4390-D, which addresses the patient population, states "in applying the 50 percent guideline (4390 C 2), determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline."

Maine DHHS determined that resident level analysis was required in these Case Mix facilities, to determine whether more than fifty percent (50%) of the residents had a behavioral health diagnosis and treatment plan that resulted in the need for residential level of care.

Subsequently Maine DHHS requested and was granted an additional extension until November 7, 2012 to assess the patient population, referenced in this report as “Resident Level Analysis”.

Maine DHHS used an assessment tool (PNMI Resident Level Assessment) much like the federal PASRR screen^{vi} to assess the patient population and need for this level of care. This analysis was conducted for Appendix C residents by a clinical team including Licensed Clinical Social Workers, a Registered Nurse, and a Medical Director. The clinical team requirements are also referenced in Section 4390(D) of the Medicaid Manual.

Maine “Appendix C” PNMI primarily treat older patients who have a combination of medical conditions and disabilities resulting in the need for personal care and medication administration. A behavioral health diagnosis is not required as eligibility for admission to Appendix C facilities, which are licensed to deliver personal care services including medication administration. These facilities do not provide active treatment for behavioral health needs. Members requiring such treatment receive it from external and separately enrolled MaineCare agencies. Generally, these personal care services delivered in an Appendix C facility are a lower level of intensity than would be delivered in a nursing facility. Maine DHHS analysis of a roster for this population in September of 2011 indicated that approximately 26% of residents were nursing facility eligible using current Maine standards. Maine DHHS staff assessed data including all diagnoses, but did not have sufficient data to determine which diagnoses were the primary reasons for needing this residential level of care. It was determined that a resident level analysis was required for these Appendix C facilities to ascertain the primary reason for those individuals needing residential care and to rule out that behavioral health diagnosis was the primary reason. The Department contracted with its PASRR agent to conduct reviews similar to PASRR Level I reviews required for nursing facility residents for all facilities where 50% or more of the residents had a recorded behavioral health diagnosis on record.

III. Discussion of Maine PNMI Programs and IMD Analysis

Maine reimburses several types of PNMI programs, varying in size and treatment specialty. Detailed descriptions of these services are provided in MaineCare Benefits Manual, Chapters II and III, Private Non-Medical Institutions, and Appendices B, C, D, E, and F.^{vii} Numbers of facilities for each type, as well as numbers of bed (residents) were ascertained by DHHS program staff and confirmed in the scattered site analysis performed by DHHS Division of Quality Improvement. The following section, arranged by PNMI appendices, provides details of program specialty and a discussion of the IMD analysis. The following chart summarizes the number of

PNMI facilities. Only the “Appendix C” facilities have more than 16 beds in one location, all other PNMI programs are in “scattered sites”.

MaineCare PNMI Appendix Summary						
	Appendix					
	B	C	D	E	F	Total
Total # Provider Agencies	5	76	13	21	24	138
Total # of Beds	120	3464	480	571	240	4875
Total # of Sites	10	125	82	104	31	352
Number Provider Agencies with 2 or more sites	5	16	10	19	3	53
Number Provider Agencies Greater Than 16 Beds (Including Scattered Sites)	4	53	9	0	3	69
Number with Greater than or Equal to 50% Clients with Mental Health Diagnosis	5	0	12	20	3	40
Number multi-site Provider Agencies with separate administrative/clinical functions	5	0	9	21	1	36

Appendix B- Substance Abuse Facilities

The Department currently has five agencies providing residential substance abuse services at ten separate sites, with approximately 120 beds. The delivery of these services in scattered sites prompted Maine’s first request for an extension of IMD analysis. A scattered site analysis was necessary to rule out IMD status for any of these provider agency programs with more than 16 beds, though none has more than 16 beds in one location. DHHS used the Medicaid Manual guidance, provider agency input and DHHS program staff summaries, and licensing information to determine that all provider agencies that operate more than one program (component) are independent in functioning so as not to be an IMD. PNMI Residential Substance Abuse services are intensive 24-hour residential programs, and are governed by MaineCare Benefits Manual, Chapters II and III, and Appendix B, Substance Abuse Facilities.

- **Discussion of Analysis:** DHHS worked with CMS in the fall of 2011 to determine whether any of these substance abuse residential facilities meet the criteria for IMD. A couple of facilities were initially identified to CMS as potential IMDs, due to the co-location of some homeless shelter services where no MaineCare funding is utilized. This identification was also complicated by the separate programs (components) and confusion as to how to identify those programs when considering Section 4390. DHHS rescinded the initial letter identifying these facilities as IMDs after consulting with CMS, and continues to assert that these programs are not IMDs.

- **Results:**

Application of Section 4390 guidelines are as follows:

- 1) These PNMI programs are licensed as Substance Abuse residential programs.
- 2) These PNMI programs are not accredited as psychiatric facilities.
- 3) These PNMI programs are under the jurisdiction of the Maine DHHS Office of Substance Abuse and Mental Health Services.
- 4) These PNMI programs specialize in the treatment of substance abuse.
- 5) All of the residents of these PNMI programs have a substance abuse (behavioral health) diagnosis.

Maine DHHS analyzed these facilities, and determined that most agencies have scattered site programs, none of which exceed 16 beds. Further analysis shows that scattered site programs operate independently in staffing and specific program focus. **After summarizing the characteristics of all of these Substance Abuse PNMI, DHHS reports that none of its substance abuse residential facilities are IMDs. Additionally, the DHHS will adopt a “scattered site” definition moving forward that will apply to all of these residential programs, to assure that no programs established or modified after this date meet IMD status.**

Appendix C- Case Mix Facilities

There are currently 76 different agencies at approximately 125 separate facilities providing services to over 3000 MaineCare residents. This type of PNMI serves about two thirds of Maine’s PNMI population, and these are the only PNMI that have more than 16 beds in one physical location. Residents in these facilities are mostly older adults with chronic health conditions that result in the need for personal care, medication administration, and nursing assistance. Many of these residents also have dementia or cognitive impairment, further increasing the need for a supported living environment. Residents receive a variety of personal care and medication administration services in these facilities, and reside in these settings primarily because they are unable to live alone in the community. A September 2011 assessment roster showed that about 26% of these residents are nursing facility eligible, though residents often choose this less intensive and more homelike PNMI setting rather than a higher level (and more expensive) level of nursing home care. An assessment tool (Medical Eligibility Determination) is used to determine eligibility for this level of care, and residents must require assistance with several activities of daily living in addition to a nursing need in order to be

eligible for this level of care. A behavioral health diagnosis is not required for admission. The assessments also include documentation of all prescribed medications.

- **Discussion of IMD Analysis** These facilities are reimbursed to deliver personal care services (assistance with activities of daily living, instrumental activities of daily living, nursing and medication administration) to adults with disabilities and chronic health conditions. These facilities do not deliver behavioral health treatment. When residents require active behavioral health treatment, the services are provided by different provider agencies that are separately licensed and enrolled. When residents receive behavioral health treatment, separately licensed and enrolled providers either come to the facility or residents are transported to the mental health provider agency for such services.

DHHS contracts with an Authorized Agent to prior authorize behavioral health services and conduct PASRR reviews on behalf of the Department, and utilized this same Authorized Agent (APS HealthCare) to review behavioral health diagnoses and treatment for these residents in Appendix C facilities. APS HealthCare did a resident level review for every facility where 50% or more of the residents had a behavioral health diagnosis recorded on their MDS-RCA assessment. This resulted in resident level reviews in 63 facilities, with 2248 residents being assessed. APS Healthcare reviewed each record to determine the primary reason for the individual requiring this level of care, excluding residents for whom dementia was the primary reason for requiring this level of care.

Upon initial review, sixty of the 63 facilities had less than 50% of their residents who “met criteria” of having a behavioral health diagnosis and active treatment for that diagnosis that appeared to be the primary reason for that individual needing this level of care. Three facilities initially exceeded the 50% threshold. One of those facilities closed in July of 2012 for financial reasons, and all residents have since been discharged and admitted to other facilities. Of the remaining two facilities in question, a nursing facility review was conducted by licensed nurses of each resident to determine whether any comorbid conditions are the primary reason for requiring this level of care, rather than a behavioral health diagnosis. A DHHS team including a Registered Nurse met with administrators and the Director of Nursing of each of the two facilities to go over all resident records. In the meeting, the team reviewed records and treatment for each member who appeared to meet criteria. For each facility, upon reviewing medical records, talking with staff, and comparing the assessments to both screens completed, it was determined that none of these facilities exceeded the 50% threshold. During these meetings, DHHS staff emphasized with the facility administrators the importance of assuring consistency that all residents be admitted on the basis of having those physical disabilities that align with the personal care services the facility is primarily enrolled to provide.

- **Results:**

Application of Section 4390 guidelines are as follows:

- 1) These PNMI programs are licensed as Assisted Living Facilities.
- 2) These PNMI programs are not accredited as psychiatric facilities.
- 3) These PNMI programs are under the jurisdiction of the Maine DHHS.
- 4) These PNMI programs specialize in the delivery of personal care services.
- 5) Some residents of these PNMI programs have behavioral health diagnoses, but this diagnosis is not required admission to the PNMI. The need for personal care services, usually due to a chronic health condition or disability, is the general requirement for admission.

DHHS does not consider any of these Appendix C facilities Institutions for Mental Disease, even though some residents do have behavioral health diagnoses. The facilities are licensed as and operate solely for the purpose of delivering personal care services, including assistance with activities of daily living and medication administration. Maine DHHS has made this determination based on careful patient assessments, and CMS guidance in the Medicaid Manual, Section 4390. A final report of this analysis is also attached.^{viii}

Appendix D- Child Care Facilities

Maine DHHS currently reimburses three distinctly different types of PNMI programs for children, Treatment Foster Care, Infant Mental Health, and Behavioral Health Residential Services. While the services in these programs are designed and licensed to meet the behavioral health needs of MaineCare members under the age of 18, the programs differ in intensity. There are currently 11 Treatment Foster Care agency providers, licensed for a total of 350 beds; 4 Infant Mental Health agency providers, with a total of 83 licensed beds; and 13 Children's Residential Program Agency Providers, licensed for 434 beds. Many of these facilities do not currently use all of their licensed beds, and are operating at or below 70% of their licensed capacity.

- **Discussion of Analysis:** DHHS did extensive analysis of children's residential services in all of these categories, an analysis that was complicated by the differing design of each of these programs. All of these PNMI residential settings are homelike in nature, provided in group homes typically having no more than 4-5 beds in one home or setting. Children who temporarily reside in these group homes get services during the day in Day Treatment programs, at a location separate from their residence, and these Day

Treatment Program services are licensed and enrolled separately. Day Treatment services are delivered as community based components, and children residing in the PNMI programs are not the only recipients of services in these Day Treatment programs. Day treatment is not billed as a PNMI service. Agency providers enroll separately and bill under Behavioral Health Services, Section 65, MaineCare Benefits Manual. These Day Treatment programs combine services in a setting that children both residing in residential care or in the community may receive. DHHS met with staff of several of the larger PNMI programs where analysis was most complex to further review their direct care and administrative staffing patterns.

- **Results:**

Application of Section 4390 guidelines are as follows:

- 1) These PNMI programs are licensed as Residential Child Care Facilities.
- 2) These PNMI programs are not accredited as psychiatric facilities.
- 3) These PNMI programs are under the jurisdiction of the Maine DHHS Office of Child and Family Services.
- 4) These PNMI programs specialize in the treatment of children's behavioral health conditions.
- 5) All of the children in these PNMI programs have a behavioral health diagnosis.

DHHS has determined that none of these children's PNMI programs are IMDs due to the scattered site delivery pattern that assures that children reside in small homelike settings with dedicated staff for each residence. This determination is strengthened by the fact that behavioral health treatment is delivered as a separate component for these programs, and is delivered in settings integrated with other community based services. Additionally, the DHHS will adopt a "scattered site" definition moving forward that will apply to all of these residential programs, to assure that no programs established or modified after this date meet IMD status.

Appendix E- Community Residences for Members with Mental Illness

Community Residences for Members with Mental Illness serve adults with behavioral health diagnoses in small homelike settings. Many individual have their own apartment, or at minimum, their own room in a 3-4 bed group home. There are currently 21 different agencies at 104 locations at which these services are provided, and there are approximately 571 licensed beds. Rules for medical eligibility, services provided, and reimbursement are detailed in the

MaineCare Benefits Manual, and Appendix E, Private Non-Medical Institutions. Many of these adult members with behavioral health diagnoses have had psychiatric hospitalizations in the past that make them part of a Consent Decree overseen by a court master.

Discussion of Analysis: All of the residential services in these programs are in settings of 16 or fewer beds. Programs in “scattered site” settings have dedicated direct care and sufficient supervisory administrative capacity (except for executive level administrative staff) to operate independently. Direct care staff are not routinely shared across programs, except for some weekend or emergency coverage. While the agencies do share medical direction and high level administrative staff, those are agency efficiencies that do not impact direct care for residents. These PNMI programs are highly integrated into the community to assure that members with behavioral health needs receive services in the least restrictive settings possible.

- **Results:**

Application of Section 4390 guidelines are as follows:

- 1) These PNMI programs are licensed by the DHHS as behavioral health PNMI programs.
- 2) These PNMI programs are not accredited as psychiatric facilities.
- 3) These PNMI programs are under the jurisdiction of the Maine DHHS Office of Substance Abuse and Mental Health Services.
- 4) These PNMI programs specialize in the treatment of behavioral health conditions for adults.
- 5) All of the residents in these PNMI programs have a behavioral health diagnosis.

The DHHS has determined that none of these facilities are IMDs. Additionally, the DHHS will adopt a “scattered site” definition moving forward that will apply to all of these residential programs, to assure that no programs established or modified after this date meet IMD status.

Appendix F- Non-Case Mix Medical and Remedial Facilities

There are four distinctly different populations served in Appendix F PNMI facilities. These facilities serve adults with brain injury, adults in DHHS Protective Services Custody, or individuals with Intellectual Disabilities, and adults with mental illness. All of these small facilities are homelike in nature; most residents have their own room in a group home setting with no more than 4-6 residents in the home. There are currently eleven brain injury agency providers, serving approximately 140 adults. There are currently 4 mental health agency providers serving 49

residents. There are 34 locations serving 210 adults with Intellectual Disabilities, and 7 locations serving 50 elders who have guardianship through Adult Protective Services Custody due to impairment in independent decision making, such as dementia.

- **Discussion of Analysis:** None of these programs have more than 16 beds. Programs at various scattered site settings do not routinely share staff, and have sufficient supervisory administrative capacity (except for executive level administrative staff) to operate independently. These programs are specifically designed to provide supportive services so that adults with disabilities can reside in least restrictive settings integrated into their community.
- **Results:**

Application of Section 4390 guidelines are as follows:

- 1) These PNMI programs are licensed by the Maine DHHS as PNMI residential programs.
- 2) These PNMI programs are not accredited as psychiatric facilities.
- 3) These PNMI programs are under the jurisdiction of the Maine DHHS.
- 4) These PNMI programs specialize in the delivery of personal care services for residents who have a variety of diagnoses and conditions.
- 5) Some of the residents in these PNMI programs have a behavioral health diagnosis, but this diagnosis is not required, since the focus of the treatment is on the delivery of personal care services.

DHHS has determined that none of these PNMI services are IMDs. Additionally, the DHHS will adopt a “scattered site” definition moving forward that will apply to all of these residential programs, to assure that no programs established or modified after this date meet IMD status.

Conclusion

After thorough analysis using a standardized assessment process and guidance from CMS federal guidelines, Maine DHHS has determined that none of its PNMI facilities meet the definition of an Institution for Mental Disease. Maine DHHS carefully considered both programmatic and resident specific factors in making this determination.

Maine DHHS staff emphasize that the unique design of its PNMI programs result in behavioral health treatment that assures treatment integrated into the community in least restrictive settings that do not meet the federal definition of an IMD.

The DHHS will adopt a “scattered site” definition moving forward that will apply to all of these residential programs, to assure that no programs established or modified after this date meet IMD status. This definition will be used in DHHS rules and regulations for residential programs.

Maine’s newly adopted Scattered Site definition is as follows:

To assure compliance with federal regulations, MaineCare does not fund services in an Institution for Mental Disease (IMD). The federal definition of an IMD is “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”

To assure that MaineCare residential services are not considered IMD services, MaineCare will not fund any behavioral health residential care level program with more than 16 beds in any single or scattered site location. A program is determined by its independent functioning within an agency, and requires its own qualified direct care staff and direct care staff supervisor or program administrator. A clinician may perform the functions of the direct care staff supervisor, the program administrator or perform the duties of both.

For agencies with more than 16 beds total, each site must meet the condition of participation independently. MaineCare recognizes independent participation as a program site that has 1) a program administrator or supervisor (or independently licensed clinician) who is responsible for the daily operations of the program; AND 2) a qualified direct care team responsible for provision of treatment services. Clinical supervision of qualified direct care staff in scattered site settings must meet the licensing requirements of all Mental Health Agencies providing Community Support and Outpatient Mental Health Services. The individual program supervisor and qualified direct care team may not be responsible for more than 16 beds.

End Notes and Attachments:

ⁱ Richard McGreal, August 9, 2011 letter;

ⁱⁱ Mary C. Mayhew, November 8, 2011 letter;

ⁱⁱⁱ Richard McGreal, April 13, 2012 letter;

^{iv} Maine DHHS PNMI Assessment Worksheet

^v Maine DHHS diagram/Decision Tree IMD Assessment Tool

^{vi} Maine DHHS PNMI Resident Level Analysis Tool

^{vii} MaineCare Benefits Manual, Chapters II and III, Private Non-Medical Institution Services, and Appendix B, Substance Abuse Facilities, C, Case Mix Facilities, D, Childcare Facilities, E, Community Residents for Persons with Mental Illness, and F, Non-Case Mix Medical and Remedial Facilities is at:
<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

^{viii} APS Healthcare: Report Name: Resident Level Screening Project- Cumulative Total

Maine DHHS

Attachment 1

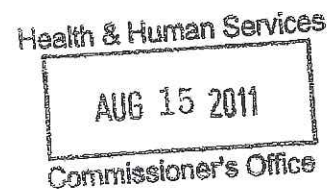
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



Division of Medicaid and Children's Health Operations/Boston Regional Office

August 9, 2011

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011



RE: Institution for Mental Disease Exclusion

Dear Commissioner Mayhew:

As you are aware, Maine Department of Health and Human Services (DHHS) and CMS have engaged in frequent telephone conferences for the last several months regarding the State's current operations of private non-medical institutions (PNMI). These conferences are the result of several pending State plan amendments (SPA) which MaineCare submitted in the fall of 2010. The SPAs are currently "off the clock" as CMS and MaineCare work together to reach an approvable status.

In the course of these discussions, we have learned many details about the PNMI programs, services, and operations. Based on the information that we have received from DHHS, it is our opinion that several of the PNMI facilities may meet the regulatory definition of institutions for mental diseases (IMD). Section 1905(a)(28) of the Social Security Act (the Act) generally excludes Medicaid coverage for services provided in an IMD and Federal Financial Participation is unavailable for services to IMD patients regardless of whether those services are provided within or outside the facility. Federal Medicaid regulations at 42 CFR 435.1010 define an IMD as:

"Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases".

Page 2 – Mary C. Mayhew, Commissioner

Additional guidance on the determination of whether a facility is an IMD can be found in section 4390 of the State Medicaid Manual.

However, as detailed below, there are situations in which Medicaid FFP is allowed for patients of IMDs:

- a) Section 1905(a)(14) of the Act permits inpatient hospital services and nursing facility services for individuals 65 years of age or over if the IMD facility meets Medicaid survey and certification requirements and is licensed as a Medicaid facility.
- b) Section 1905(a)(16) of the Act permits inpatient psychiatric services for patients who are under the age of 21 (or age 22 for those receiving such services when attaining age 21).
- c) Also, for patients aged 65 and over, FFP is permitted for non-institutional services regardless of whether the IMD is licensed as an inpatient facility.

Please note that, other than the special situation noted in (b), none of these exceptions apply to IMD services for patients who are between ages 21 and 65.

Due to the above-expressed concerns, we are asking the State to identify all PNMI facilities that meet the Federal definition of an IMD and then immediately cease Medicaid claiming for services in that IMD. Please submit this list to my office within 60 days of receipt of this letter. CMS cannot guarantee that other entities with oversight responsibility of the Medicaid agency will not pursue compliance actions, within their authority, with respect to Medicaid payment to these IMDs.

Please feel free to contact me with any questions you may have regarding this letter.

Yours,



Richard McGreal
Associate Regional Administrator

Attachment 2



**Department of Health
and Human Services**

*Maine People Living
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707
Fax (207) 287-3005; TTY: 1-800-606-0215

November 8, 2011

Richard McGreal, Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Building, Government Center
Room 2275
Boston, Massachusetts 02203

**Re: CMS August 9, 2011 Letter Regarding IMD Exclusion
And October 24, 2011 Telephone Conference**

Dear Mr. McGreal:

Thank you for taking the time to talk with us October 24. During that phone call, you requested a timeline of how long a scattered site/IMD analysis would take the Department to complete. We estimate a comprehensive analysis would take approximately 6 months, and we would have the results to you by May 7, 2012.

Again, thank you for your time and thoughtful consideration of our questions regarding this complicated issue. We look forward to working with you, as I expect we will have questions for you as we proceed through this process.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

cc: Bonnie Smith, Deputy Commissioner of Programs
Stefanie Nadeau, Director, Office of MaineCare Services
Patricia Dushuttle, Director, Policy, Office of MaineCare Services
Pamela Easton, Director of Program and Regulatory Accountability

Attachment 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

April 13, 2012

Mary C. Mayhew, Commissioner
Department of Health and Human Services
221 State Street
11 State House Station
Augusta, Maine 04333-0011

Dear Commissioner Mayhew:

We have reviewed your March 19, 2012 letter regarding the State's request for an extension to November 7, 2012 to complete its Institute of Mental Disease (IMD) analysis; as you are aware, this is an additional six months from the current deadline of May 7, 2012. We are granting your extension request to complete the review, but we will require the State to provide us with regular progress updates.

We would like the following information submitted to the Maine State Lead, Kathryn Holt, on a monthly basis:

1. The initial total number of facilities/homes reviewed;
2. The number of facilities/homes still needing review; and
3. A timeline depicting how all facilities/homes will be reviewed in time for final determinations to be made by November 7, 2012.

As you are aware, the State must immediately cease claiming FFP for all Medicaid services provided to individuals residing in a facility determined to be an IMD.

An additional point of clarification may be necessary based on the information provided in your March 19th letter regarding the existence of depression in some residents of PNMI Case Mix facilities. Please note that the "need for institutionalization" must be a person's mental disease; therefore, irrespective of whether a person has a primary or secondary diagnosis of depression, mental disease must be a factor for why they require institutionalization.

Please feel free to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Richard R. McGreal".

Richard R. McGreal
Associate Regional Administrator

Attachment 4

Private Non-Medical Institution (PNMI) Assessment Worksheet

Name of Person Completing Form: _____ Date: _____

NPI + 3 Number: _____

Facility/Provider Name: _____

Facility Provider Type: _____

Facility Provider Specialty: _____

Address of the Facility: _____

Contact Phone: _____ Contact: _____

Name and Title of Person Providing Responses: _____

Name of Owner of the Facility: _____

Owner Address: _____

Total Number of beds: _____

Number of Beds designated for PNMI services: _____

Percent of total population with a primary mental health diagnosis: _____

Description of population served (i.e. elderly, mentally ill etc.): _____

Does the Facility/Provider have multiple service locations: ☐ Yes ☐ No

If "YES" PLEASE BE SURE TO COMPLETE DETAIL CHART ON Page #3.

INSTRUCTIONS: REFER TO THE REFERENCE SHEET FOR A LIST OF DEFINITIONS.

SECTION 1: Please complete this section to determine if the facility should be assessed as having a separate facility/component or as a single entity:

Does the facility have more than one service location? ☐ Yes ☐ No

1. Are the components of the facility certified as different types of providers? i.e. NFs and hospitals.
☐ Yes ☐ No
2. Are all components controlled by one owner or one governing body?
☐ Yes ☐ No
3. Is one chief medical officer responsible for the medical staff activities in all components?
☐ Yes ☐ No
4. Does one chief executive officer control all administrative activities in all components?
☐ Yes ☐ No
5. Are any of the components separately licensed?
☐ Yes ☐ No
6. Are the components so organizationally separate that it is not feasible to operate as a single entity? ***Please answer a, b & c in response to this question***
 - a. Does each component have separate administrative staff?
☐ Yes ☐ No
 - b. Does each component have a separate Executive Director, Chief Operating Officer, Chief Executive Officer or Finance Director?
☐ Yes ☐ No
 - c. Does each component have a separate central office building?
☐ Yes ☐ No
7. Are the components so geographically separate that it is not feasible to operate as a single entity? ***Please answer a & b in response to this question***
 - a. Are the components located within the same county?
☐ Yes ☐ No
 - b. Are the components more than 50 miles away from each other?
☐ Yes ☐ No
8. Are two or more of the components participating under the same provider category (such as NFs)?
☐ Yes ☐ No
 - a. If NO, go onto next question
 - b. If YES, can each component meet the conditions of participation independently?
☐ Yes ☐ No
9. Is the facility licensed as a psychiatric facility?
☐ Yes ☐ No
10. Is the facility accredited as a psychiatric facility?
☐ Yes ☐ No

SECTION 2: Please complete the following section if the facility has more than 16 beds and there is more than one location.

Please list each of the Service Locations and answer the questions for each:

FACILITY								
NAME								
Number of total beds								
Number of beds designated for PNMI								
Type of facility								
NPI + 3 if available								
11 Does this facility provide services to mentally ill persons?								
12 Is the facility under the jurisdiction of the State's mental health authority?								
13 Does the facility specialize in providing psychiatric/ psychological care and treatment?								
13a Do more than 50% of staff have specialized psychiatric/psychological training?								
13b Do more than 50% of patients receive psychopharmacological drugs?								
13c Are goals related to treating a mental health disorder included in the treatment plans?								
13d Are more than 50% of staff hours dedicated to treating a mental health disorder?								
14 Does the <u>current</u> need for institutionalization for more than 50% of the patients in the facility result from mental disease? <i>*If it is not possible to make a determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the last year. Do not include a patient in the mentally ill category when no clear cut distinction is possible</i>								
14a Was the patient admitted to the facility because of an issue resulting from a mental disease								
14b Does the patient's current need for institutionalization result from a mental disease?								

SECTION 3: For Nursing Facilities Only

When completing this section use the reference page for definitions relevant to this section.

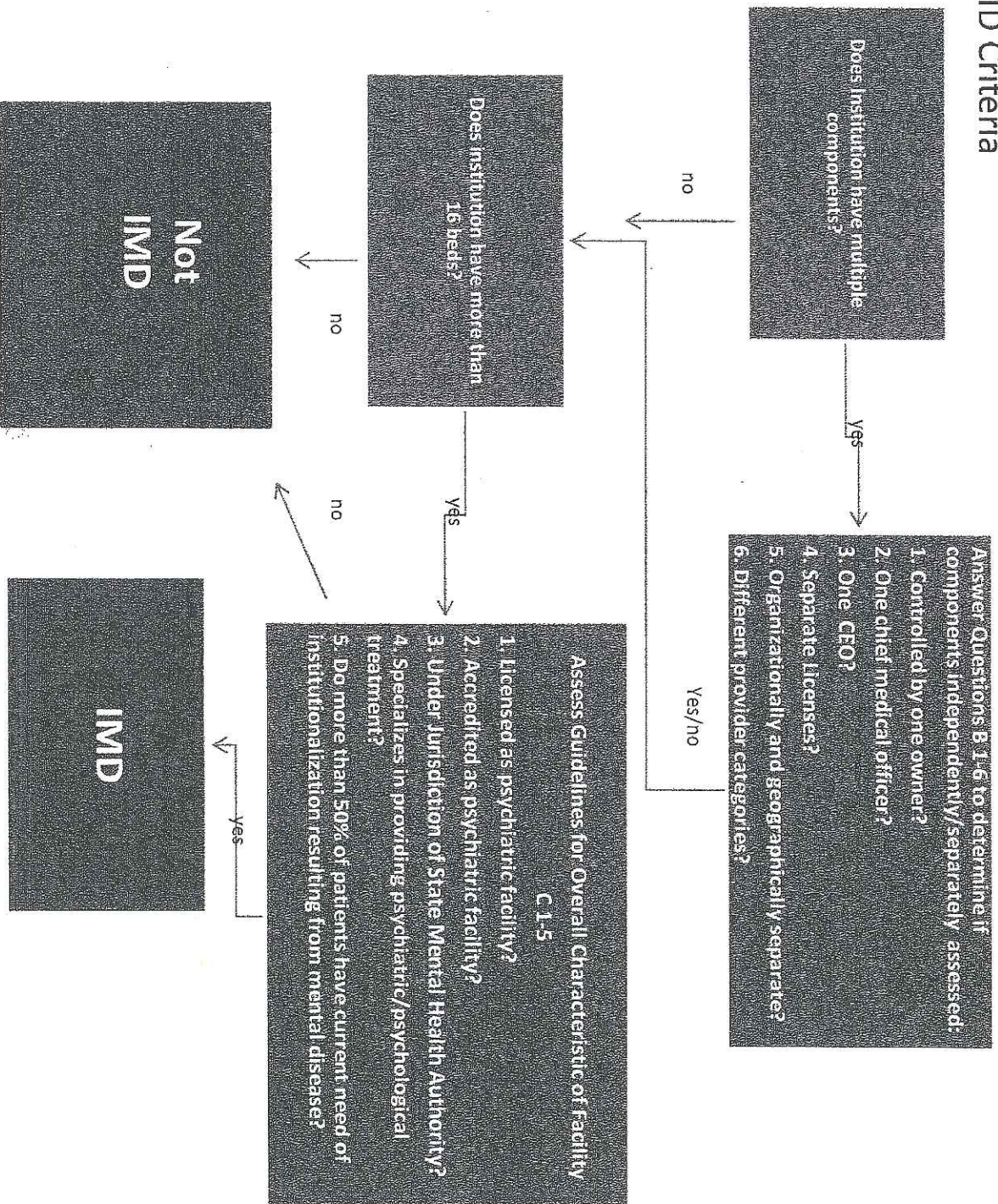
15. What is the average age of the patients in this Nursing Facility? _____
16. Do more than 50% of residents in this Nursing Facility require specialized services for the treatment of serious mental illnesses? **When making this determination, please focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.**
- ☐ Yes ☐ No

SECTION 4: Substance Abuse Facilities Only

17. Does the treatment provided in the facility follow a psychiatric model? i.e. any model that focuses on psychiatric ailments and does not rely on a peer counseling model (i.e. Alcoholics Anonymous)
- ☐ Yes ☐ No
18. If yes, is this treatment provided by medically trained and licensed personnel? If no, please go to question 19.
- ☐ Yes ☐ No
19. Are services Psychological in nature? i.e. do the services provided target psychological functions and/or address psychological diagnoses?
- ☐ Yes ☐ No
20. Is the facility limited to services based on the Alcoholics Anonymous model? i.e. they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors.
- ☐ Yes ☐ No

Attachment 5

Medicaid Manual Section 4390 IMD Criteria



Attachment 6



PNMI APPENDIX C

RESIDENT LEVEL SCREEN

Instructions: This Resident Level Screen contains 3 sections: *All 3 sections must be completed.*

Facility Name: _____

Date: ____/____/____ Fax#: _____ Phone #: _____

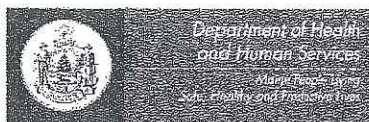
Print Name and Title of Person Completing Form _____

Signature _____

Section I: Identification and Background Information

1. Resident's Name:	First: _____ (MI): _____ Last: _____
2. Address:	Street: _____ City/Town: _____ State: _____ Zip: _____ County: _____ Phone: _____
3. Social Security #:	_____
4. MaineCare #:	_____
5. Medicare #:	_____
6. Date of Birth:	Month: _____ Day: _____ Year: _____
7. Emergency Contact:	Name: _____ Street: _____ City/Town: _____ State: _____ Zip: _____ Relationship: _____ Phone: _____ Is this person his/her Legal Guardian? <input type="checkbox"/> No <input type="checkbox"/> Yes or Medical Power of Attorney? <input type="checkbox"/> No <input type="checkbox"/> Yes

Any determination regarding the resident level screen must be made by the
Department of Health & Human Services (DHHS) or designee.



PNMI APPENDIX C RESIDENT LEVEL SCREEN

Resident's Name: _____

Section II: Resident Level Screen: Reason for Admission

The following questions are asking about the individual's reason for admission to the PNMI Appendix C facility. In answering these questions, **please consider, upon admission to the facility, why the individual was no longer independent with any of the following:** activities of daily living (ADLs – ie: personal hygiene, toileting, bathing, eating, dressing), instrumental activities of daily living (IADLs – ie: housework, meal preparation, grocery shopping, managing finances), medication administration, self-direction, or overall ability to live independently.

1. Is **dementia the primary cause of his/her functional impairment** and therefore, the **primary** reason for this individual's need for PNMI Appendix C level of care?

- ☐ No
☐ Yes

2. Is **a medical condition the primary cause of his/her functional impairment** and therefore, the **primary** reason for this individual's need for PNMI Appendix C level of care?

- ☐ No
☐ Yes. Please specify what condition: _____

3. Is **a traumatic head injury, stroke, intellectual disability (MR) or other cognitive impairment the primary cause of his/her functional impairment** and therefore, the **primary** reason for this individual's need for PNMI Appendix C level of care?

- ☐ No
☐ Yes. Please specify what cognitive condition: _____

4. Is **a mental illness the primary cause of his/her functional impairment** and therefore, the **primary** reason for this individual's need for PNMI Appendix C level of care?

- ☐ No
☐ Yes. Please specify what diagnosis: _____

5. Is **another condition that is not listed above, the primary cause of his/her functional impairment** and therefore, the **primary** reason for this individual's need for PNMI Appendix C level of care?

- ☐ No
☐ Yes. Please specify what condition: _____

Any determination regarding the resident level screen must be made by the
Department of Health & Human Services (DHHS) or designee.



PNMI APPENDIX C

RESIDENT LEVEL SCREEN

Resident's Name: _____

Section III: Resident Level Screen: Mental Health Diagnosis and Treatment

1	Does the individual have a mental illness diagnosis? (<i>dementia is not a mental illness diagnosis</i>)
	<input type="checkbox"/> No (<i>please answer the rest of the questions on the page, even when there is no documented diagnosis</i>) <input type="checkbox"/> Yes
2	Diagnosis (Dx): _____ DSM Code: _____ (Number Required)
2a	This diagnosis has existed for how long? _____
3	Is the individual receiving any active treatment for a mental illness , demonstrated by:
a.	Any active goals on the individual's PNMI Plan of Care related to treating a mental health disorder, symptoms or behaviors? <input type="checkbox"/> No <input type="checkbox"/> Yes
b.	Any hospitalization for psychiatric treatment, in the past 2 years (<i>and <u>not</u> for the treatment of dementia</i>)? <input type="checkbox"/> No <input type="checkbox"/> Yes
c.	Outpatient psychiatric medication services (<i>by a psychiatrist or psych. NP, <u>not</u> from a PCP</i>)? <input type="checkbox"/> No <input type="checkbox"/> Yes
d.	If yes, please list current psychiatric medications: _____
e.	Outpatient psychotherapy services? <input type="checkbox"/> No <input type="checkbox"/> Yes
f.	Mental health Case Management services (<i>aka Community Integration Svcs.</i>)? <input type="checkbox"/> No <input type="checkbox"/> Yes
g.	Mental health Daily Living Support Services (DLSS) via an outside community mental health agency? <input type="checkbox"/> No <input type="checkbox"/> Yes
h.	An assessment from Crisis Response Services, or police involvement, in the past 2 years? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Fax to: APS Healthcare at 1-866-325-4752 Attention: RLS Coordinator ★ ★ ★ ★ ★ For questions re: the Resident Level Screen, or how to complete this form, CALL: 1-866-521-0027, ask for the RLS Coordinator.

Any determination regarding the resident level screen must be made by the
Department of Health & Human Services (DHHS) or designee.

Attachment 7

MaineCare Benefits Manual,
Chapter II, Chapter III, and
Appendices B, C, D, E, and F:

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Attachment 8

Report Name: Resident Level Screening Project - Cumulative Total

Start: 06/01/2012 End: 11/11/2012

Report Source: Data from APS CareConnection®

Report Run Date: November 6, 2012

What This Report Measures: The number of Resident Level Screens completed and entered into APS CareConnection to date and the results of these screens. The choices for the results of the screening are:

"Does not meet criteria" = Mental illness is not the primary reason for the individual's need for residential care.

"Dementia waiver" = Dementia is the primary reason for the individual's need for residential care.

"Meets criteria & age 18-64" = A serious mental illness is the primary reason for the individual's need for residential care and is between the ages of 18 and 64, as of 7/1/12.

"Meets criteria & age 65 and over" = A serious mental illness is the primary reason for the individual's need for residential care and is age 65 or over, as of 7/1/12.

Background: APS Healthcare contacted 63 Appendix C Residential Facilities that appeared to have more than 50% of its residents with a primary diagnosis of a serious mental illness. This baseline data was from PNMI MD-RCA Assessment Data from the Final 9/15/2011 Payment Roster prepared March 2012 by the Office of Medicaid Services. In June 2012, each identified facility was asked to fax PHI information to APS about the primary reason for admission and the current mental health status of (each of the current) all residents in its facility. APS clinical staff reviewed the information (and) on the completed resident level screens and entered this information into APS Care Connection. Approximately 2,304 resident level screens are slated to be completed by September 1, 2012. Upon the completion of this project, the facilities that meet the criteria of 50% or more of their residents' primary reason for needing residential care is a serious mental illness will be identified

Appendix C Facility	Address	Does not meet criteria	Dementia Waiver	Meets criteria & age 18 -64	Meets criteria & age 65 and over	% Meets Criteria	# of RLS completed
1 Arbor Manor	11-13 PLAISTED STREET GARDNER, ME 04345	26	3	5	4	24%	38
2 Auburn Residential Care Center	185 SUMMER STREET AUBURN, ME 04210	23	2	1	5	19%	31
3 Bayview Manor	45 WEST MAIN SEARSPORT, ME 04974	16	4	1	5	23%	26
4 Berwick Estates	79 PORTLAND STREET SO. BERWICK, ME 03908	20	10	1	0	3%	31
5 Biddeford Estates	2 DARTMOUTH ST. BIDDEFORD, ME 04005	51	27	0	11	12%	89
6 Bolster Heights RCF	26 BOLSTER ST AUBURN, ME 04210	63	10	5	4	11%	82
7 Capitol City Manor	313 STATE ST. AUGUSTA, ME 04330	13	2	6	7	46%	28
8 Clark's Terrace at The Park	777 STEVENS AVENUE PORTLAND, ME 04103	18	5	0	2	8%	25
9 Danforth - Assisted Living Clover Manor	440 MINOT AVE AUBURN, ME 04210	73	11	0	9	10%	93
10 Colonial Healthcare	36 WORKMAN TERRACE LINCOLN, ME 04457	22	3	0	1	4%	26

Appendix C Facility		Address	Does not meet criteria	Dementia Waiver	Meets criteria & age 18-64	Meets criteria & age 65 and over	% Meets Criteria	# of RLS completed
11	Country village Assisted Living	P.O. BOX 600 CASCO, ME 04015	13	7	0	1	5%	21
12	Country village Estates	260 DUGAL DRIVE MADAWASKA, ME 04756	13	4	0	0	0%	17
13	Crest View Manor	361 COURT STREET HOULTON, ME 04730	9	3	6	1	37%	19
14	Crosswinds Residential Care	40 VILLAGE ROAD FORT KENT, ME 04743	19	5	0	3	11%	27
15	Davis Estates	14 STACKPOLE ROAD MACHIAS, ME 04654	18	8	5	2	21%	33
16	Dexter Boarding Home	45 MAIN STREET DEXTER, ME 04930	11	1	4	4	40%	20
17	Dionne Commons	24 MAURICE DR BRUNSWICK, ME 04011	31	20	1	3	7%	55
18	Dolley Farm	98 EAST BRIDGE ST. WESTBROOK, ME 04092	14	8	5	4	29%	31
19	Edgewood Rehabilitation & Living Center	221 FAIRBANKS ROAD FARMINGTON, ME 04938	17	3	0	0	0%	20
20	Elder Care Maine - Gray Manor	9 LEWISTON ROAD GRAY, ME 04039	17	1	6	3	33%	27
21	Freeport Place	4 OLD COUNTY RD FREEPORT, ME 04032	17	8	0	2	7%	27
22	Fryeburg Health Care Center	70 FAIRVIEW DR. FRYEBURG, ME 04037	20	12	1	3	11%	36
23	Hall-Dale Manor	385 MAINE AVE. FARMINGDALE, ME 04344	13	2	4	6	40%	25
24	Hilltop Manor	462 ESSEX STREET DOVER-FOXCROFT, ME 04426	15	4	0	3	14%	22
25	Inn at Atlantic Heights	100 HARBOR DRIVE SACO, ME 04072	27	6	0	1	3%	34
26	Island Nursing Home-Homeport	ROUTE 15 DEER ISLE, ME 04627	21	9	1	0	3%	31
27	Janus Supportive Living Services	276 RAZORVILLE ROAD WASHINGTON, ME 04574	18	2	11	3	41%	34
28	Ledgeview Living Center	141 BETHEL ROAD WEST PARIS, ME 04289	12	11	0	0	0%	23
29	Limestone Manor, Inc	6 CHURCH STREET LIMESTONE, ME 04750	22	7	4	3	19%	36

Appendix C Facility	Address	Does not meet criteria	Dementia Waiver	Meets criteria & age 18 -64	Meets criteria & age 65 and over	% Meets Criteria	# of RLS completed
30 Maine General Medical Center	37 GRAYBIRCH DRIVE AUGUSTA, ME 04330	33	0	1	2	8%	36
31 Maine Veterans Homes - South Paris	477 HIGH ST SO. PARIS, ME 04281	16	7	0	0	0%	23
32 Market Square HCC	3 MARKET SQUARE SOUTH PARIS, ME 04281	16	1	2	2	19%	21
33 Montello Manor	540 COLLEGE ST. LEWISTON, ME 04240	38	2	0	1	2%	41
34 North Country Associates - Borderview Rehab & Living	90 STATE STREET VAN BUREN, ME 04785	29	18	2	2	8%	51
35 North Country Associates - Country Manor	MAIN STREET COOPERS MILLS, ME 04341	8	6	1	3	22%	18
36 North Country Associates - Courtland Rehab & Living	42 BUCKSPORT RD ELLSWORTH, ME 04605	11	7	0	1	5%	19
37 North Country Associates - Narraguagus Bay Health Care	MAIN STREET MILBRIDGE, ME 04658	14	6	0	3	13%	23
38 North Country Associates - Sonogee Rehabilitation & Living	131 EDEN STREET BAR HARBOR, ME 04609	19	5	0	1	4%	25
39 Norway Rehabilitation and Living Center	29 MARION AVE NORWAY, ME 04268	19	6	0	0	0%	25
40 Penobscot Nursing Home	MAIN ST PENOBSCOT, ME 04476	23	1	4	8	33%	36
41 Phillips Strickland House	21 BOYD STREET BANGOR, ME 04401	21	8	0	3	9%	32
42 Portland Center - Assisted Living Facility	68 DEVONSHIRE ST PORTLAND, ME 04103	87	41	3	17	14%	148
43 Ridgewood Estates	480 RIDGEVIEW AVE MADAWASKA, ME 04576	25	12	1	3	10%	41
44 Russell Park Manor	158 RUSSELL ST. LEWISTON, ME 04240	35	12	2	1	6%	50
45 Sarah Frye Home	751 WASHINGTON STREET AUBURN, ME 04210	23	12	0	1	3%	36
46 Schooner Estates Residential Care	200 STEINSON ROAD AUBURN, ME 04210	25	2	0	0	0%	27
47 Seaside Rehabilitation & Healthcare	850 BAXTER BLVD PORTLAND, ME 04103	21	2	2	3	18%	28
48 Seven Tree Manor	132 MIDDLE ROAD UNION, ME 04862	19	1	8	8	44%	36

Appendix C Facility	Address	Does not meet criteria	Dementia Waiver	Meets criteria & age 18 -64	Meets criteria & age 65 and over	% Meets Criteria	# of RLS completed
49 Seventy-Five State Street	75 STATE STREET PORTLAND, ME 04101	25	10	1	4	13%	40
50 Skolfield House	26 CUMBERLAND ST. BRUNSWICK, ME 04011	40	3	0	1	2%	44
51 Snow Pond RCC	RT 23, POND ROAD SIDNEY, ME 04330	11	4	2	4	29%	21
52 Somerset Rehab & Living Center	PREBLE AVE MADISON, ME 04950	9	5	0	0	0%	14
53 Southern Acres Residential Care	203 TWEEDIE RD WESTFIELD, ME 04787	15	4	3	8	37%	30
54 St. Joseph's Manor	1133 WASHINGTON AVE PORTLAND, ME 04103	34	2	1	2	8%	39
55 Sunset Home	114 COLLEGE AVE WATERVILLE, ME 04901	18	0	0	2	10%	20
56 The Chapman House	41 PLEASANT STREET AUBURN, ME 04210	21	7	0	0	0%	28
57 The Lodges Care Center, Inc	51 MAIN STREET SPRINGVALE, ME 04083	28	17	1	9	18%	55
58 Victorian Villa Rehab & Living Center	PLEASANT ST, PO BOX 636 CANTON, ME 04221	32	7	9	6	28%	54
59 Volmer Country Living Center	513 MAIN STREET VASSALBORO, ME 04989	8	6	0	2	13%	16
60 Washington Place	40 PALMER ST CALAIS, ME 04619	19	5	1	2	11%	27
61 Woodlands Assisted Living of Hallowell	152 WINTHROP ST. HALLOWELL, ME 04347	26	17	0	6	12%	49
62 Woodlands of Brewer	53 COLONIAL CIRCLE BREWER, ME 04412	59	5	2	0	3%	66
Totals		1,479	439	113	195	14%	2,226

*Biddeford Estates is also known as York Manor.